Please Check for which this applies:
Massage Therapy ☐
Athletic Therapy ☐
Physiotherapy ☐
Dietitian ☐
Reflexology ☐

Confidential Patient Case History Form

Name (please print):________________________________ Date:________________
Address:____
City:______________________ Postal Code:_______________
Phone: (H)_________________(B)____________________(C)__________________
Email: ____
Date of Birth: ___________________ Sex: M __ F __
MD's Name:________________________________ MD's Phone#: ________________

Current Medications (including nonprescription):
____
____

Allergies:
____

Direct Billing Information

☐	Blue Cross	Contract #__________________	Group #_________________
☐	GWL	Plan # ____________________	ID #_______________
☐	DVA/RCMP	Group K #__________________	Authorization #_________________
☐	MPI	Claim #_____________________	Case Manager __________________
☐	WCB	Claim #_____________________	Case Manager __________________

Your insurance benefit is a contract between you & your insurance company.

It is the responsibility of the patient to keep track of number of visits related to insurance coverage maximums.

Please provide a credit card number below if we do direct billing for you. The card will only be charged if we are denied payment from the insurance company.

Visa/MC Card#_____________________________ Exp. date _____________ VIN # ___________

****Failure to provide 24 hour notice of appointment cancellation will result in a 50% charge of your scheduled appointment**.** I, the undersigned, acknowledge and understand the preceding content and agreement. If under 18 please have parent or guardian sign.

Name:_____________________________________ Signature:______________________

Medical History

We collect the following information to assist the therapist in planning your treatment program. This questionnaire allows us to focus on your present problems considering what has happened in the past.

What is you primary complaint?

____

Can you describe it? DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF
Pain scale: (low) 1--------5--------10 (high) Does it radiate anywhere?

____

Does anything aggravate your symptoms?

____

Does anything relieve your symptoms?

____

When did your symptoms begin?

____

Have they changed & how?

____

Is this condition interfering with: WORK SLEEP DAILY ROUTINE ACTIVITIES
(please
explain)____
____

Have you seen any other health care practitioner concerning this complaint? Medical Dr. /
Chiropractor / Physiotherapist / Massage Therapist / Other :_____________________
Have they provided results?

____

Surgery/injuries/hospitalization: (date, past & current
symptoms)____
____

Do you have any internal pins/wires/artificial joints?

____

Please check all that apply.

HEAD / NECK
Headache ☐
Migraine ☐
Visual Disturbances ☐
Contact lenses/glasses ☐
Earaches ☐
Hearing problems ☐
Jaw Pain ☐
Whiplash ☐
Concussion ☐

CARDIOVASCULAR
High / Low pressure ☐
Chronic heart failure ☐
Poor Circulation ☐
Heart Disease ☐
Phlebitis ☐
Varicose Veins ☐
Stroke ☐
Heart Attack ☐
Pacemaker ☐
Arteriosclerosis ☐
Irregular heart beat ☐

RESPIRATORY
Asthma ☐
Chronic cough ☐
Shortness of breath ☐
Bronchitis ☐

DIGESTIVE / URINARY
Difficult Digestion ☐
Constipation ☐
Liver / Gallbladder ☐
Kidney / Urinary ☐
Diabetes (type) ☐
Hypoglycemia ☐
Crohn's disease ☐
Irritable Bowel ☐
Ulcers ☐

SKIN
Bruise easily ☐
Eczema ☐
Psoriasis ☐
Sensitivity ☐
Skin Condition ☐
(please explain)
Loss of Sensation ☐
Athlete's Foot ☐
Cold Sores ☐
Plantar Warts ☐

INFECTIOUS CNDTNS
Tuberculosis ☐
AIDS /HIV ☐
Hepatitis ☐
Infectious Skin ☐

MUSCLE / JOINTS
Neck ☐
Lower Back ☐
Mid Back ☐
Upper Back ☐
Shoulder ☐
Hip ☐
Knee ☐
Ankle ☐
Other ☐

FEMALE
Menstrual problems ☐
Pregnancy ☐
Due Date:
Menopausal issues ☐
Gynaecological problems ☐

OTHER
Hemophiliac ☐
Epilepsy ☐
Cancer (explain) ☐
Arthritis ☐ OA / RA
Fibromyalgia ☐
Osteoporosis ☐
Chronic Fatigue ☐
Scoliosis ☐
Carpal tunnel syndrome ☐
Dizziness/fainting ☐
Hernia ☐

Any other information that you want our therapists to know:

____

____

Consent for Treatment and Release of Medical Information

I, the undersigned, give consent to Avani Wellness to assess and initiate treatment.

Name:________________________________ Signature:______________________

I also authorize the release of medical information to my physician and case managers/ adjustors in the case of a MPI, WCB or other private insurance claim. If under 18 please have parent or guardian sign.

Name:________________________________ Signature:______________________